

**Medicare Utilization.** (1)(a) Prior to February 1, 1996 the commissioner of health shall calculate the result of the statewide total of residential health care facility days of care provided to Medicare beneficiaries, divided by the sum of such days of care plus days of care provided to residents eligible for payments pursuant to title 11 of article 5 of the social services law, expressed as a percentage, for the period commencing July 1, 1995 to the last date for which such data is available and reasonably accurate. This value shall be called the 1995 statewide target percentage.

(b) Prior to February 1, 1997, the commissioner of health shall calculate the result of the statewide total of residential health care facility days of care provided to beneficiaries of title XVIII of the federal social security act (Medicare), divided by the sum of such days of care plus days of care provided to residents eligible for payments pursuant to title 11 of article 5 of the social services law, expressed as a percentage, for the period commencing January 1, 1996 through November 30, 1996 based on such data for such period as is available and reasonably accurate. This value shall be called the 1996 statewide target percentage.

(c) Prior to February 1, 1998, the commissioner of health shall calculate the result of the statewide total of residential health care facility days of care provided to beneficiaries of title XVIII of the federal

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social security act (Medicare), divided by the sum of such days of care plus days of care provided to residents eligible for payments pursuant to title 11 of article 5 of the social services law minus the number of days provided to residents receiving hospice care, expressed as a percentage, for the period commencing January 1, 1997 through November 30, 1997 based on such data as is available and reasonably accurate. This value shall be called the 1997 statewide target percentage.

(d) Prior to February 1, 1999, the commissioner of health shall calculate the result of the statewide total of residential health care facility days of care provided to beneficiaries of Title XVIII of the federal social security act (Medicare), divided by the sum of such days of care plus days of care provided to residents eligible for payments pursuant to title 11 of article 5 of the social services law minus the number of days provided to residents receiving hospice care, expressed as a percentage, for the period commencing January 1, 1998 through November 30, 1998 based on such data as is available and reasonably accurate for such period. This value shall be called the 1998 statewide target percentage.

(e) Prior to February 1, 2000 the commissioner of health shall calculate the result of the statewide total of residential health care

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# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

9 9 - 3 5

2. STATE:

New York

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE

July 1, 1999

TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

Section 1902(a) of the Social Security Act

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-D Part 1 Pages 33(a), 47(x)(4),  
47(x)(7), 47(x)(8), 47(x)(9), 47(x)(10), 47(x)(11),  
47(x)(12), 47(x)(13), 47(x)(14), 47(x)(15), 47(x)(16),  
51(a)

7. FEDERAL BUDGET IMPACT:

a. FFY 1998-1999 \$ (29,178,498)

b. FFY 1999-2000 \$ (27,535,502)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):

Attachment 4.19-D Part 1 Pages 33(a),  
47(x)(4), 47(x)(7), 47(x)(8), 47(x)(9), 47(x)(10),  
47(x)(11), 47(x)(12), 47(x)(13), 47(x)(14),  
47(x)(15)

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page 47(x)(16)

10. SUBJECT OF AMENDMENT:

Long Term Care Services

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT

☒ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Antonia C. Novello, M.D., M.P.H.

14. TITLE:

Commissioner

15. DATE SUBMITTED:

September 30, 1999

16. RETURN TO:

New York State Department of Health  
Corning Tower  
Empire State Plaza  
Albany, New York 12237

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For the purposes of establishing the indirect component of the rate of payment for services provided on or after April 1, 1995 through March 31, 1999 and for services provided on or after July 1, 1999 through March 31, 2000, the reimbursable base year costs as reported in the fiscal services and administrative services functional cost centers, as specified in subparagraphs (i) and (ii) of this paragraph of a provider services, excluding a provider of services reimbursed on an initial budget basis, shall not exceed the statewide average of total reimbursable base year administrative and fiscal service costs. For the purposes of this paragraph, reimbursable base year administrative and fiscal service costs shall mean those base year administrative and fiscal services costs remaining after application of all other efficiency standards, including, but not limited to, peer group ceilings or guidelines. The limitation on reimbursement for provider administrative and general expenses provided by this paragraph shall be expressed as a percentage reduction of the operating cost component to the rate promulgated for each residential health care facility.

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(x) Residential health care facility rates of payment for services provided on or after July 1, 1995 through March 31, 1996 shall be reduced by the Commissioner to reflect the elimination of operational requirements previously mandated by law or regulation or the Commissioner or other governmental agency, by a factor determined as follows:

(i) an aggregate reduction shall be calculated for each residential health care facility as the result of (a) up to fifty-six million dollars on an annualized basis for 1995, trended to the rate year by the trend factor for projection of reimbursable costs to the rate year, multiplied by (b) the ratio of patient days for patients eligible for payments made by government agencies provided in a base year two years prior to the rate years by a residential health care facility, divided by the total of such patient days summed for all residential health care facilities; and

(ii) the result for each residential health care facility shall be divided by such patient days for patients eligible for payment made by governmental agencies provided in the residential health care facility, for a per diem reduction in rates of payment for such residential health care facility for patients eligible for payments made by governmental agencies.

(iii) Effective April 1, 1996 through March 31, 1999 and on or after July 1, 1999 through March 31, 2000, residential health care facility rates of payment shall be reduced by an annual aggregate amount of fifty-six million dollars to encourage improved productivity and efficiency. Actual reduction in rates within such aggregate amounts will be allocated among facilities based upon each facility's ratio of Medicaid utilization to total statewide Medicaid utilization for all residential health care facilities.

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facility days of care provided to beneficiaries of Title XVIII of the federal social security act (Medicare), divided by the sum of such days of care plus days of care provided to residents eligible for payments pursuant to title 11 of article 5 of the social services law minus the number of days provided to residents receiving hospice care, expressed as a percentage, for the period commencing January 1, 1999 through November 30, 1999 based on such data for such period. This value shall be called the 1999 statewide target percentage.

(2) Prior to February 1, 1996, the commissioner of health shall calculate the results of the statewide total of health care facility days of care provided to Medicare beneficiaries, divided by the sum of days of care plus days of care provided to residents eligible for payments pursuant to title 11 of article 5 of the social services law, expressed as a percentage, for the period April 1, 1994 through March 31, 1995. This value shall be called the statewide base percentage.

(3) (a) If the 1995 statewide target percentage is not at least one percentage point higher than the statewide base percentage, the commissioner of health shall determine the percentage by which the 1995 statewide target percentage is not at least one percentage point higher than the statewide base percentage. The percentage calculated pursuant to this paragraph shall be called the 1995 statewide reduction percentage. If the

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statewide target percentage is at least one percentage point higher than the statewide base percentage, the statewide reduction percentage shall be zero.

(b) If the 1996 statewide target percentage is not at least two percentage points higher than the statewide base percentage, the commissioner of health shall determine the percentage by which the 1996 statewide target percentage is not at least two percentage points higher than the statewide base percentage. The percentage calculated pursuant to this subdivision shall be called the 1996 statewide reduction percentage. If the 1996 statewide target percentage is at least two percentage points higher than the statewide base percentage, the 1996 statewide reduction percentage shall be zero.

(c) If the 1997 and 1998 statewide target percentages are not for each year at least three percentage points higher than the statewide base percentage, the commissioner of health shall determine the percentage by which the statewide target percentage for each year is not at least three percentage points higher than the statewide base percentage. The percentage calculated pursuant to this paragraph shall be called the 1997 or 1998 statewide reduction percentage respectively. If the 1997 or 1998 statewide target percentage for the respective year is at least three percentage points

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higher than the statewide base percentage, the statewide reduction percentage for the respective year shall be zero.

(d) If the 1999 statewide target percentage is not at least two and one-quarter percentage points higher than the statewide base percentage, the commissioner of health shall determine the percentage by which the 1999 statewide target percentage is not at least two and one-quarter percentage points higher than the statewide base percentage. The percentage calculated pursuant to this paragraph shall be called the 1999 statewide reduction percentage. If the 1999 statewide target percentage is at least two and one-quarter percentage points higher than the statewide base percentage, the 1999 statewide reduction percentage shall be zero.

(4) (a) The 1995 statewide reduction percentage shall be multiplied by thirty-four million dollars to determine the 1995 statewide aggregate reduction amount. If the 1995 statewide reduction percentage shall be zero, there shall be no reduction amount.

(b) The 1996 statewide reduction percentage shall be multiplied by sixty-eight million dollars to determine the 1996 statewide aggregate reduction amount. If the 1996 statewide reduction percentage shall be zero, there shall be no reduction amount.

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(c) The 1997 statewide reduction percentage shall be multiplied by one hundred two million dollars to determine the 1997 statewide aggregate reduction amount. If the 1997 statewide reduction percentage shall be zero, there shall be no 1997 reduction amount.

(d) The 1998 statewide reduction percentage shall be multiplied by one hundred two million dollars to determine the 1998 statewide aggregate reduction amount. If the 1998 statewide reduction percentage shall be zero, there shall be no 1998 statewide reduction amount.

(e) The 1999 statewide reduction percentage shall be multiplied by seventy-six million five hundred thousand dollars to determine the 1999 statewide aggregate reduction amount. If the 1999 statewide reduction percentage shall be zero, there shall be no 1999 reduction amount.

(5) (a) The 1995 statewide aggregate reduction amount shall be allocated by the commissioner of health among residential health care facilities that are eligible to provide services to Medicare beneficiaries and residents eligible for payments pursuant to title 11 of article 5 of the social services law on the basis of the extent of each facility's failure to achieve a one percentage point increase in the 1995 target percentage compared to the base percentage, calculated on a facility specific basis for this purpose, compared to the statewide total of the extent of each facility's

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failure to achieve a one percentage point increase in the 1995 target percentage compared to the base percentage. This amount shall be called the 1995 facility specific reduction amount.

(b) The 1996, 1997, [and] 1998, and 1999 statewide aggregate reduction amounts shall for each year be allocated by the commissioner of health among residential health care facilities that are eligible to provide services to Medicare beneficiaries and residents eligible for payments pursuant to title 11 of article 5 of the social services law on the basis of the extent of each facility's failure to achieve a two percentage points increase in the 1996 target percentage, [and] a three percentage point increase in the 1997 and 1998 target percentage and a two and one-quarter percentage point increase in the 1999 target percentage for each year, compared to the base percentage, calculated on a facility specific basis for this purpose, compared to the statewide total of the extent of each facility's failure to achieve a two percentage points increase in the 1996, a three percentage point increase in the 1997, and a three percentage point increase in the 1998 and a two and one-quarter percentage point increase in the 1999 target percentage compared to the base percentage. These amounts shall be called the 1996, 1997, [and] 1998 and 1999 facility specific reduction amounts

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(6) The facility specific reduction amounts shall be due to the state from each residential health care facility and may be recouped by the state in a lump sum amount from payments due to the residential health care facility pursuant to title 11 of article 5 of the social services law.

(7) Residential health care facilities shall submit such utilization data and information as the commissioner of health may require for purposes of this section. The commissioner of health may use utilization data available from third party payers.

(8)(a) On or about June 1, 1996, the commissioner of health shall calculate for the period July 1, 1995 through March 31, 1996 statewide target percentage, statewide aggregate reduction amount, and a facility specific reduction amount in accordance with the methodology provided in paragraphs 1(a), 3(a), 4(a) and 5(a) of this provision. The facility specific reduction amount calculated in accordance with this paragraph shall be compared to the 1995 facility specific reduction amount calculated in accordance with paragraph 5(a) of this provision. Any amount in excess of the amount determined in accordance with paragraph 5(a) of this provision shall be due to the state from each residential health care facility and may be

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recouped in the same manner as specified in paragraph 6 of this provision. If the amount is less than the amount determined in accordance with paragraph 5(a) of this provision, the difference shall be refunded to the residential health care facility by the state no later than July 15 1996. Residential health care facilities shall submit utilization data for the period July 1, 1995 through March 31, 1996 to the of health by April 15, 1996.

(b) On or about June 1, 1997, the commissioner of health shall calculate for the period January 1, 1996 through November 30, 1996 a statewide target percentage, a statewide reduction percentage, a statewide aggregate reduction amount, and a facility specific reduction amount in accordance with the methodology provided in paragraph 1(b), 3(b), 4(b) and 5(b) of this provision. The facility specific reduction amount calculated in accordance with this paragraph shall be compared to the 1996 facility specific reduction amount calculated in accordance with paragraph 5 (b) of this provision. Any amount in excess of the amount determined in accordance with paragraph 5(b) of this provision shall be due to the state from each residential health care facility and may be recouped in the same manner as specified in paragraph 6 of this provision. If the amount is less than the amount determined in accordance with paragraph 5(b) of this provision, the difference shall be

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refunded to the residential health care facility by the state no later than July 15, 1997. Residential health care facilities shall submit utilization data for the period January 1, 1996 through November 30, 1996 to the commissioner of health by April 15, 1997.

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(F)(1) On or about September first of each year, the consultants shall provide to the Commissioner and the State Hospital Review and Planning Council, the methodology to be used to determine the trend factors for the rate period, commencing on the next January first. The Commissioner shall monitor the actual price movements during these periods of the external price indicators used in the methodology. shall report the results of the monitoring to the consultants and shall implement the recommendations of the consultants for one prospective interim annual adjustment to the initial trend factors to reflect such price movements and to be effective on January first, one year after the initial trend factors were established.

(2) Notwithstanding the dates specified in paragraph (1), the consultants shall provide as soon as possible to the Commissioner and the State Hospital Review and Planning Council, the methodology to be used to determine the trend factor for the rate period April 1, 1991 to December 31, 1991. One prospective interim annual adjustment for this rate period shall be made on January 1, 1992 and one prospective final annual adjustment for this rate period shall be made on January 1, 1993.

(g) For reimbursement of services provided to patients for the period April 1, 1995 through December 31, 1995, the trend factors established in accordance with subdivisions (d), (e) and (f) of this section shall reflect no trend factor projections and no trend factor adjustments applicable to periods prior to January 1, 1995 other than those reflected in 1994 rates of payment and provided further, that this subdivision shall not apply to use of the trend factor for the January 1, 1995 through December 31, 1995 period, any interim adjustment to the trend factor for such period, or the final trend factor for such period for purposes of projection of allowable operating costs to subsequent rate periods. The Commissioner of Health shall adjust rates of payment to reflect the exclusion of trend factor projections pursuant to this subdivision. For reimbursement of services provided to patients effective April 1, 1996 through March 31, 1997, the rates will be established by the Commissioner of Health without trend factor adjustments for prior periods.\* For reimbursement of services provided to patients on and after April 1, 1996 through March 31, 1999 and for payments made on and after July 1, 1999 through March 31, 2000, the rates shall reflect no trend factor projections or adjustments for the period April 1, 1996 through March 31, 1997.

<sup>1</sup>This means that since the rates for the April 1, 1996 through March 31, 1997 period are based on 1983 base year costs trended to this period, the rate impacts of any differences between, say, the final value of the 1995 trend factor and the preliminary 1995 trend factor value that may have been used when initially calculating the rate, would be incorporated into the rates for the April 1, 1996 through March 31, 1997 rate period.

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For the purposes of establishing the indirect component of the rate of payment for services provided on or after April 1, 1995 through March 31, 1999 and for services provided on or after July 1, 1999 through March 31, 2000, the reimbursable base year costs as reported in the fiscal services and administrative services functional cost centers, as specified in subparagraphs (i) and (ii) of this paragraph of a provider services, excluding a provider of services reimbursed on an initial budget basis, shall not exceed the statewide average of total reimbursable base year administrative and fiscal service costs. For the purposes of this paragraph, reimbursable base year administrative and fiscal service costs shall mean those base year administrative and fiscal services costs remaining after application of all other efficiency standards, including, but not limited to, peer group ceilings or guidelines. The limitation on reimbursement for provider administrative and general expenses provided by this paragraph shall be expressed as a percentage reduction of the operating cost component to the rate promulgated for each residential health care facility.

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